Supreme Court, U.S.
FILED
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No. 07-763

In The

Supreme Court of the United States

SHIRLEY A. GRAHAM,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY

Respondents.

Supplemental Appendix to
Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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Case 4:03-cv-00144-JOE-SAJ Document 21
Filed in USDC ND/OK on 04/22/2005

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY GRAHAM	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 03-CV-0144-JOE
	)	
HARTFORD LIFE INSURANCE COMPANY	)	
	)	
Defendant	)	

ORDER

The Court instructed both parties to submit briefs as to whether the Employment Retirement Security Act of 1974 (ERISA) is applicable to this case and, if so, whether ERISA preempts the state law claims asserted by the Plaintiff, Shirley Graham ("Graham").

Graham was employed for a number of years as a rural letter carrier by the United States Postal Service (USPS). As a USPS employee, Graham was a member of the National Rural Letter Carrier's Association (NRLCA), the official bargaining representative for rural letter carriers employed by the USPS. NRLCA's stated purpose is as follows: "The purpose of this Association shall be to improve the methods used by rural letter carriers, to benefit their conditions of labor with the United States Postal Service, and to promote fraternal spirit among its members." NRLCA has its own National Board and Executive Committee, has its own National Headquarters and maintains its own insurance department.

There exists a collective bargaining agreement (CBA) between USPS and NRLCA. Under the CBA, USPS is obligated to provide certain employee benefits to employees, including pension benefits, medical benefits and life insurance benefits. The CBA does not require USPS to provide a disability plan to members of the NRLCA.

Because USPS does not offer a disability benefit plan to rural letter carriers, NRLCA established a disability plan for those USPS employees who were NRLCA members. In a letter to its members, the NRLCA notified its members of the Plan and described it as follows:

> Dear Member,:
>
> The National Rural Letter Carriers' Association (NRLCA) is pleased to a offer long term disability income protection plan for its regular rural carrier (Designation 71) members.
>
> The disability income plan is designed to protect your most valuable asset, your income, in the event of a disabling illness or accident. Postal employees do not have a long term disability plan that is sponsored by the U.S. Postal Service. So the NRLCA has worked diligently over the past several years to develop and sponsor a disability plan for its regular carrier members.
>
> As a regular rural carrier, you now have the opportunity to enroll in a plan which provides affordable income protection coverage through the NRLCA. The Rural Letter Carrier Long Term Disability (RLCLTD) plan is entirely voluntary but we hope that you

> will seriously consider the benefits of this coverage and enroll NOW!!
>
> The Plan is sponsored by the NRLCA and underwritten by the Hartford Life and Accident Insurance Company..

In the same letter, NRLCA advised its members that they should direct any questions about the Plan to the NRLCA insurance department. The Plan enrollment form provides for NRCLA members to either request or decline coverage and to return the form, giving the return address of the "RLCLTD Plan Administrator, NRLCA Group Insurance Department, 1630 Duke Street, Alexandria, VA." The only involvement of the USPS with respect to the Plan is that members who enroll authorize automatic deductions from their wages in order to pay premiums.

The NRLCA, in order to provide disability benefits to members under the Plan, obtained a group long-term disability policy from Hartford. Under the group policy, NRLCA is the policyholder, and benefits are provided to the eligible class defined as, "All active full-time regular rural letter carrier (designation 71) members". Graham, as a member of the NRLCA, enrolled in the NRLCA Plan. She claims to be disabled and brought a claim under the Plan.

ERISA Preemption

ERISA comprehensively regulates, among other things, employee welfare benefit plans that, 'through the purchase of insurance or otherwise,' provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. *Pilot Life Ins. Co. V Dedeaux*, 481 U.S. 41, 44, 107 S. Ct. 1549, 95 L.Ed. 2d 39 (1987). The Supreme Court has expressly stated that ERISA's preemption provisions are "deliberately expansive." *Id* at 46, 107

S.Ct. 1549; see also *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, 103 S.Ct. 2890, 77 L.Ed. 2d 490 (1983).

ERISA governs "employee benefit plan[s]."29 U.S.C.§1003(a). One form of employee benefit plan is an "employee welfare benefit plan." *Id. §1002(3).* An employee welfare benefit plan is:

> any plan, fund, or program ... established or maintained by an employer or by an employee organization ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance ... medical, surgical, or hospital care or benefits ... in the event of sickness, accident, disability,....*Id. §1002(1)*

The "preemption clause" (§514(a)) of ERISA provides that ERISA supercedes all state laws insofar as they "relate to any employee benefit plan." ERISA's "saving clause" (§514(b)(2)(A)) excepts from the preemption clause any state law that "regulates insurance". ERISA's "deemer clause" (§514(b)(2)(B)) provides that no employee benefit plan shall be deemed to be an insurance company for purposes of any state law "purporting to regulate insurance."

The main dispute in the present case is whether this particular plan is exempted from ERISA under the "government plan exclusion." Under 29 U.S.C. §1003(b)(1), "government plans" are excluded from the provisions of ERISA. A government plan is defined in 29 U.S.C. §1002(32) as:

The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the

Government of any state or political subdivision thereof or by any agency or instrumentality of any of the foregoing...

The Plaintiffs brief appears to assume that the union representing the rural carriers is one and the same as the USPS and then argues that it is obvious that the USPS is a part of the Government of the United States. The Court does not accept Plaintiffs argument and the Court finds that the disability plan in question does not meet the criteria to be a "government plan", and therefore, be excluded from ERISA constraints.

The Court finds the analysis of this issue in *Culpepper v. Protective Life Ins. Co.*, 938 F.Supp. 794, 798-800 (M.D. Ala. 1996) particularly persuasive. In *Culpepper*, the court adopted factors from NLRB cases and from the Internal Revenue Code to determine if the organization creating the plan could be considered a "political subdivision" of the state or federal government. "In determining whether an entity is a political subdivision under 29 U.S.C. § 1002(32), the court must consider whether the entity was `(1) created directly by the state, so as to constitute departments or administrative arms of the government, or (2) administered by individuals who are responsible to public officials or the general electorate' ". *Culpepper* at 798, citing *Rose v. Long Island R.R. Pension Plan*, 828 F.2d 910, 916 (2d. Cir 1987).

The *Culpepper* court also relied on six factors borrowed from the Revenue Ruling 57-128 of the Internal Revenue Service which determined whether an entity was a "political subdivision" under §414(d) of the Internal Revenue Code. *Culpepper* at 798.[1]

---

[1]The factors were: (1) whether it is used for a governmental purpose and performs a governmental function;

This Court finds that none of the tests applied by the Rose case or the Internal Revenue Code are satisfied in the present case.

The only significant fact that is present in Culpepper, which is not before this Court is that, in Culpepper, membership in the Alabama National Guard Association was purely voluntary and not a requirement to be employed with the National Guard. In the present case, it is unclear whether membership in the NRLCA was a requirement for employment. However, assuming that membership was required, the Court does not find that difference significant enough to change the Court's ruling. The union was formed for the benefit of its members and, often, the union's position would be in direct conflict with the employer. It is clear that employer did not control the union, did not support the union financially, and the union did not perform a governmental function. Therefore, the union plan does not qualify as a "government plan".

Bad Faith Claim

Because there is no question that the tort of insurance bad faith "relates to" the NRLCA's disability policies, which is an ERISA-regulated employee benefit plan, Graham's state law claim for

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(2) whether performance of its function is on behalf of one or more states or political subdivisions; (3) whether there are any private interests involved, or whether the states or political subdivisions involved have the powers and interests of an owner; (4) whether control and supervision of the organization is vested in public authority or authorities; (5) if express or implied statutory or other authority is necessary for the creation and/or use of such an instrumentality, and whether such authority exists; and (6) the degree of financial autonomy and the source of its operating expenses.

bad faith is preempted unless exempted from preemption by the saving clause. That clause exempts from preemption "any law ... which regulates insurance." 29 U.S.C.§1144(b)(2)(A). However, the Tenth Circuit has already ruled in *Gaylor v. John HancockMut. Life Ins. Co* 112 F.3 d 460 (10"' Cir.1997) , that the Oklahoma law of bad faith does not fall under the savings clause because it does "not regulate the spreading of policyholder risk". *Gaylor* at 466.

The civil enforcement provisions of ERISA §1132(a) were intended to be the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits, and Graham is restricted to that enforcement vehicle. Graham's state law claim for bad faith is hereby dismissed.

Within 45 days of the date of this Order, the parties shall submit to the Court the complete administrative record for the Court's review.

Dated this 22nd day of April, 2005.

/s/ James O. Ellison
James O. Ellison
U.S. District Judge

Case 4:03-cv-00144-CVE-SAJ Document 33
Filed in USDC DN/OK on 01/20/2006

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	
Plaintiff,	
vs.	**Case No. 03-CV-0144-CVE**
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	
Defendant.	

OPINION AND ORDER

Plaintiff filed this action to recover benefits and to enforce her rights under the Employee Retirement Income Security Act of 1974,29 U.S.C. § 1101 et sue. ("ERISA"). Plaintiff challenges the decision by Hartford Life & Accident Insurance Company ("Hartford") to deny her claim for Long Term Disability ("LTD") benefits under her employer's group disability plan.

I.

Plaintiff was employed from November 1976 to July 2000 as a rural letter carrier by the United States Postal Service (USPS). Plaintiff was a member of the National Rural Letter Carrier's Association (NRLCA), the official bargaining representative for rural letter carriers employed by the USPS. The NRLCA, in order to provide benefits to members, obtained a group long-term disability policy from Hartford. As a member of the NRLCA, plaintiff became a participant in the Rural Letter

Carrier Long Term Disability Plan (the "Plan"). Administrative Record ("Adm. Rec.") at Hart-Graham 2-31 (subsequent references omit the Bates-stamp prefix). The NRLCA Plan is governed by ERISA. Dkt. # 21.

Plaintiff filed an application for LTD benefits on October 27, 2000. Her last day of work was July 15, 2000, when she reported that she became unable to work due to ankle surgery and ongoing problems with her ankles and knees. Plaintiff attributes her underlying injury to an on-the-job accident that occurred on February 7, 1994 while she was trying to get away from a dog. She began care with the Eastern Oklahoma Orthopedic Center on February 8, 1994. Since this initial injury, plaintiff has experienced multiple complications with her knees and ankles. She complains of chronic, moderately severe pain in both knees and weakness in both knees. She underwent surgery on her right knee on March 3, 1997, after which the USPS offered her a posit on as a Modified Rural Carrier, a sedentary job designed specifically to accommodate her physical condition. Adm. Rec. at 135. Plaintiff alleges that her condition worsened due to the development of osteoarthritis in both knees and both ankles. She argues that a decline in her health led to her retirement in 2000. On December 1, 2000, the United States Office of Personnel Management approved plaintiff for disability retirement. Id. at 240-41.

Upon receipt of plaintiffs claim, Hartford assigned a claims specialist who reviewed submitted documents and solicited additional materials from plaintiff, her primary orthopedic surgeon, Dr. Jeffrey Emel, and her employer. In a July 26, 2000 letter from Dr. Emel to the United States Department of Labor, he reported that "Mrs. Graham has significant osteoarthritis involving both knees and both ankles. An ambulatory job would be counterproductive for her.... I really do not think she

will be able to continue her work capacities and recommend that you consider her for Disability retirement." Id. at 81. The claims specialist contacted Dr. Emel to have him clarify whether plaintiff's condition affected her ability to perform a sedentary job and, on January 23, 2001, Dr. Emel responded that "no it does not but [the patient] has retired." Id. at 165. Based on this information, Hartford denied her claim in a letter dated February 28, 2001. Id. at 159-63.

Defendant contends that plaintiffs claim was denied because she failed to meet the policy definition of "total disability." According to the Plan, "total disability" means that the participant is unable, by reason of disability, to perform the essential duties of her occupation and as a result is earning less than 20% of her pre-disability earnings. Id. at 19. The Plan further requires a claimant to submit a "proof of loss" and states, "All proof submitted must be satisfactory to us." Adm. Rec. at 15. Under the Plan, Hartford is accorded "full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy." Id. at 16. Hartford is both the payor and the claims administrator of the Plan.

In response to plaintiffs application for a review of the denial, Hartford assigned a new claims specialist to review the record as submitted by plaintiff. Dr. Emel wrote a letter dated March 7, 2001, stating that severe chondromalacia of the left knee prevented plaintiff from driving or sitting "for more than an hour at any one time." Id. at 133. Hartford did not enlist medical professionals to examine plaintiff or her medical records. The Hartford claim examiner noted that plaintiffs modified position with the USPS had been designed in 1997 to allow her to sit, elevate her feet, stand and walk as needed. Id. at 127-29. Finding that such

accommodation enabled plaintiff to perform the essential duties of her occupation, Hartford denied plaintiff's request for reconsideration on August 3, 2001. Id.

Plaintiff made a second appeal on September 26, 2001 of the decision to terminate her benefits. Id. at 125-26. During this stage of the appeals process, plaintiff supplemented the record with a personal letter describing her condition, but no further medical reports were submitted. Using a different appeal specialist, Hartford denied this appeal on November 27, 2001, again relying on the accommodation granted to plaintiff in 1997. Adm. Rec. at 74-76. Thereafter, plaintiff sought an additional review of her claim on February 21, 2003, but was informed that she had exhausted the appeals process. Id. at 38.

II.

On February 27, 2003, plaintiff filed suit, alleging defendant violated 29 U.S.C. § 1132 in denying her claim for benefits. As a plan beneficiary, plaintiff has the right to federal court review of benefit denials under ERISA. "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989). Specifically, section 1132(a)(1)(B) grants plaintiff the right to bring a civil action to recover benefits or to enforce her rights under the terms of the Plan. A denial of benefits challenged under section 1132(a)(1)(B) is to be reviewed under an arbitrary and capricious standard when a plan gives the administrator or other fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of a plan. See Bruch, 489 U.S. at 115; Nance v. Sun Life Assurance Co. of Canada, 294 F.3d 1263, 1267-68 (10th Cir. 2002) (language that

claimant must submit "proof satisfactory to" insurer conferred discretion). The parties agree that the Plan gives Hartford such discretionary authority.

The issue, then, is whether defendant acted arbitrarily and capriciously when it made the final decision to deny plaintiffs claim for LTD benefits. Under the two-tier "sliding scale" approach adopted by the Tenth Circuit, an "additional reduction in deference is appropriate" where there is an inherent or proven conflict of interest. Fought v. Unum Life Ins. Co. of America, 379 F.3d 997, 1006 (10th Cir. 2004). It is undisputed that Hartford has an inherent conflict of interest as it is both payor and claims administrator of the Plan. As such, there is a reduction in deference to the administrator's decision and Hartford "bears the burden of proving the reasonableness of its decision." Id.

Hartford "must establish by substantial evidence that its denial of benefits was reasonable." Fought, 379 F.3d at 1014. "Substantial evidence is such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the [decisionmaker]. Substantial evidence requires more than a scintilla but less than a preponderance." Sandoval v. Aetna Life and Cas. Ins., Co., 967 F.2d 377, 382 (10th Cir. 1992) (internal citations and quotation marks omitted). The Court considers the record as a whole. Caldwell v. Life Ins. Co. of North America, 287 F.3d 1276, 1282 (10th Cir. 2002). However, the Court considers only that information available to the plan administrator at the time the decision was made. Hall v. Unum Life Ins. Co. of Am., 300 F.3d 1197, 1201 (10th Cir. 2002). Therefore, the materials plaintiff submitted with her purported third appeal after the final denial on November 27, 2001 are not properly part of the record.

The Court must "take into account whatever

in the record fairly detracts from the weight of the evidence in support of the administrator's decision." Washington v. Shalala, 37 F.3d 1437, 1439 (10th Cir. 1994) (internal citations and quotation marks omitted). "Evidence is not substantial `if it is overwhelmed by other evidence -- particularly certain types of evidence (, that offered by treating physicians), or if it really constitutes not evidence but mere conclusion.'" Knipe v. Heckler, 755 F.2d 141, 145 (10th Cir. 1985) (citation omitted). The Court gives less deference to an administrator's conclusions if the administrator fails to gather or examine relevant evidence. See Caldwell, 287 F.3d at 1282. Yet, the Court "will not set aside a [] decision if it was based on a reasonable interpretation of the plan's terms and was made in good faith." Trujillo v. Cyprus Amax Minerals Co., Ret. Plan Comm., 203 F.3d 733, 736 (10th Cir. 2000).

III.

The Court finds that Hartford's decision to deny plaintiff's claim for LTD benefits was arbitrary and capricious. Hartford has not met its burden of proving the reasonableness of its decision by substantial evidence. Hartford referenced, as the basis for its determination, the 1997 accommodation for plaintiffs disability and Dr. Emel's January 23, 2001 statement that plaintiff's medical condition "does not" restrict her from work. By relying on the 1997 USPS accommodation to justify the denial, Hartford suggests that once an individual requests and receives accommodation for a disability, she foregoes future eligibility for LTD benefits. Hartford undertook no independent medical review of changes in plaintiffs condition between the accommodation in 1997 and her retirement in 2000. Absent additional evidence, prior accommodation does not amount to substantial evidence on which to base a denial of LTD benefits. See Hawkins v. First Union Core, Long-Term Disability Plan, 326 F.3d 914, 918 (7th

Cir. 2003) ("A disabled person should not be punished for heroic efforts to work by being held to have forfeited his entitlement to disability benefits should he stop working").

Further, Hartford's reliance on Dr. Emel's January 23, 2001 statement, which favors their decision, ignores his July 26, 2000 statement that plaintiff is disabled and his March 7, 2001 statement that she is incapable of sitting for more than one hour. The record suggests that Hartford gave undue weight to the January 23, 2001 statement. See Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003) ("Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence . . ."). In addition, while independent medical examinations are not required to establish reasonableness, "[w]here, as here, a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent evaluation." Fought, 379 F.3d at 1015; see Gaither v. Aetna Life Ins. Co., 388 F.3d 759, 773 (10th Cir. 2004) ("fiduciaries cannot shut their eyes to readily available information when the evidence in the record suggests that the information might confirm the beneficiary's theory of entitlement and when they have little or no evidence in the record to refute that theory.").

IV.

In summary, defendant failed to establish by substantial evidence that its denial of benefits was reasonable. Viewing the record as a whole, defendant failed to offer "more than a scintilla" of evidence to support its denial. Sandoval, 967 F.2d at 382. The Court finds that defendant's decision to deny plaintiffs claim for LTD benefits was arbitrary and capricious.

IT IS THEREFORE ORDERED that defendant's November 27, 2001 final decision to deny plaintiffs claim for LTD benefits is hereby **REMANDED** to the Plan administrator for a full and fair redetermination of the claim.

DATED this 20th day of January, 2006.

/s/ Claire V. Eagan
Claire V. Eagan
U.S. District Judge

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Filed in USDC ND/OK on 01/20/2006

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	)
	)
Plaintiff,	)
	)
vs.	)**Case No 03-CV-**
	)**0144-CVE**
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	)
	)
Defendant.	)

JUDGMENT

This action has come before the Court for consideration and an Opinion and Order (Dkt. # 33) has been entered remanding the decision of defendant, Hartford Life & Accident Insurance Company, as administrator of the Long-Term Disability Plan (the "Plan").

Pursuant to the Court's Opinion and Order, judgment is hereby entered remanding the case to the Plan administrator for a full and fair redetermination of the claim.

DATED this 20th day of January, 2006.

/s/ Claire V. Eagan
Claire V. Eagan
U.S. District Judge

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 03-CV-0144-CVE
	)	
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	)	
	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION

Comes on for Report and Recommendation Plaintiffs Application for Attorney Fees Pursuant to 29 U.S.C. §11 32(g)(1) [Dkt.#35-1] in which Plaintiff seeks attorney fees against Defendant in the amount of $22,230.00. Having considered the arguments and authorities presented by the parties, the undersigned recommends that Plaintiffs motion for attorney fees be denied.

I. BACKGROUND AND PROCEDURAL HISTORY

Plaintiff filed this action on February 27, 2003, alleging breach of the duty of good faith and fair dealing, and seeking actual and punitive damages arising from Defendant's denial of Plaintiffs claim that she was entitled to long term disability insurance payments. Plaintiff was originally represented by attorneys Mike Jones and Alan Souter.

On April 15, 2004, after several continuances of the initial status conference requested bythe parties, Judge James O. Ellison held initial status conference and ordered

simultaneous briefs to be filed on July 29, 2004, on the applicability of ERISA to Plaintiffs claims. That same day, attorney Joseph F. Clark entered an appearance in the case on behalf of Plaintiff. The Court also entered a scheduling order allowing limited discovery based upon the briefing date. The minute order following the initial status conference stated that once these issues were resolved, the parties would submit an additional joint status report and a scheduling order would be entered as appropriate.

The Court entered an Order on April 22, 2005, finding that Plaintiffs claim was subject to ERISA and her state law claim for bad faith was therefore preempted. Accordingly, this claim was dismissed. The Order further provided a schedule under which the parties were to submit the complete administrative record for the Court's review. A briefing schedule followed.

On October 3, 2005, the case was reassigned to Judge Claire V. Eagan and on January 20, 2006, Judge Eagan entered an Order remanding the case to the Plan Administrator for a full and fair redetermination of the claim.

On February 3, 2006, Plaintiff filed the pending motion which was referred to the undersigned.

II. REQUEST FOR ATTORNEY FEES

Plaintiff requests attorney fees pursuant to 29 U.S.C. § 11 32(g)(1) which provides that "in any action under this subchapter ... by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1). This is not a prevailing party statute and the award is discretionary with the Court.

The Tenth Circuit Court of Appeals in *Gordon v. United States Steel Corp.*, 724 F.2d 106 (10th Cir. 1983), provides guidance as to when an award of attorney fees is appropriate. Five non-exhaustive factors are to be evaluated as follows:

> [W]hen determining whether to award attorney's fees under section 1132(g)(1), the district court should consider these factors among others: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to personally satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions.

Gordon, 724 F.2d at 108.

Applying these to the case at bar, the record does not indicate that Defendant acted in bad faith nor did the District Court so find. Rather, the District Court concluded that Defendant's actions were arbitrary and capricious because the decision was not supported by substantial evidence. Plaintiff argues that under Oklahoma insurance law, a judgment would have appropriately been rendered for breach of the obligation of good faith and fair dealing. There is nothing before this Court to substantiate that claim.

As to the second factor, there is no discussion regarding the ability of the Defendant to pay. In regard to the third factor, the fact that an

administrator erred in one case will not necessarily serve as a deterrent to other administrators.

The fourth factor is whether the parties requesting the fees sought to benefit all participants or resolve a significant legal question regarding ERISA. Plaintiffs lawsuit appears primarily directed to impact Plaintiffs benefits.

The fifth factor is the relative merits of the parties' positions. This weighs in favor of Plaintiff. However, it is important to note the District Court did not make an outright award to Plaintiff. Rather, the case was remanded. Case law indicates fees are generally not awarded in a remanded action where there is no definitive finding of bad faith in spite of actions by a defendant which are more egregious than the actions of this Defendant. *See e.g., Lewis v. ITT Hartford Life & Accident Ins. Co.*, 395 F. Supp 1053 (D. Kan. 2005); *Krogh v. Chamberlain*, 708 F. Supp. 1235(D.Utah 1989). The same result can be found where outright benefits were conferred. *Britton v. Long Term Disability Ins. Plan of the Lovelace Inst.*, 217 F. Supp. 2d 1207 (D. N.M. 2002). Accordingly, this Court recommends no attorney fees be awarded herein pursuant to *Gordon*.

The Court finds this recommendation is further supported by Defendant's assertion that Plaintiffs fee application should be denied, or in the alternative, reduced based upon Plaintiff having failed to meet her burden of proof. The Court agrees, concluding that even if Plaintiff succeeded in establishing entitlement under *Gordon*, Plaintiffs application fails on this ground.

An award of attorney fees is the product of a reasonable number of hours expended on the litigation multiplied by a reasonable hourly rate which results in the lodestar calculation. *Burk v. City of Oklahoma City*, 598 P.2d 659 (Okla. 1979). It

is the Plaintiffs burden to establish entitlement to fees and reasonableness of both hours and hourly rate. *Beard v. Teska*, 31 F.3d 942 (10"' Cir. 1994).

Plaintiff has submitted only a two page exhibit containing time entries totaling 74.10 hours at a billable rate of $300 per hour. The verification at the bottom of page two simply states the entries represent the actual time spent on the [referenced] work according to the time records kept by Joseph F. Clark, Jr. There is no evidence from which this Court can ascertain whether the rate of $300 an hour is in line with those prevailing in the community for similar services by lawyers of comparable skill, experience, and reputation. *Ellis v. University of Kansas Medical Center*, 163 F.3d 1186 (10t" Cir. 1999), citing *Malloy v. Monahan*, 73 F.3d 1012 (10th Cir. 1996). Additionally, there is nothing in the record from which the Court can determine how long counsel has practiced, whether his practice is concentrated in this and/or other areas of law, or what reputation he has within the legal community. Even if he had provided sufficient information establishing his customary rate is $300, which he did not, or that $300 is the rate he charged this client, these factors would fall short of the required proof.

Further, Plaintiff had the right and the opportunity to rectify the deficiencies in his application by filing a reply brief pursuant to N.D.LCvR 7.2(h). Plaintiff did not file a reply brief nor timely request additional time within which to file reply brief.

Ill. RECOMMENDATION

The undersigned recommends Plaintiffs Application for Attorney Fees Pursuant to 29 U.S.C. §1132(g)(1) [Dkt.#35-1] be denied for the reasons stated herein.

IV. OBJECTIONS

In accordance with 28 U.S.C. § 636(b) and Fed. R. Civ. P. 72(b), a party may file specific written objections to this Report and Recommen lation. Objections must be filed with the Clerk of the District Court for the Northern District of Oklahoma within 10 days of being served with a copy of this Report and Recommendation. See Fed. R. Civ. P. 6 (as to computation of time periods). If specific written objections are timely filed, the district judge assigned to this case will

> make a *de novo* determination upon the record, or after additional evidence, of any portion of the magistrate judge's disposition to which specific written objection has been made in accordance with this rule. The district judge may accept, reject, or modify the recommended decision, receive further evidence, or recommit the matter to the magistrate judge with instructions.

Fed. R. Civ. P. 72(b). *See also* 28 U.S.C. § 636(b)(1).

The Court of Appeals for the Tenth Circuit has adopted a "firm waiver rule" in connection with appeals from orders adopting a Magistrate Judge's report and recommendation. "[T]he failure to make timely objections to the magistrate's findings or recommendations waives appellate review of factual and legal questions." *United States v. One Parcel of Real Property*, 73 F.3d 1057, 1059 (10th Cir. 1996) (quoting *Moore V. United States*, 950 F.2d 656, 659 (10th Cir. 1991)). **Thus, a timely, specific and written objection is necessary to preserve an issue for de novo review by the assigned district judge and for appellate review by the court of appeals**. *See Thomas v. Am*, 474 U.S. 140 (1985); *Haney v. Addison*, 175 F.3d 1217 (10th Cir. 1999); and *Talley*

v. Hesse, 91 F.3d 1411 (10th Cir. 1996).

DATED THIS 22nd DAY OF May 2006.

/s/ Sam A. Joyner
Sam A. Joyner
United States Magistrate Judge

Case 4:03-cv-00144-CVE-SAJ Document 46 Filed in USDC ND/OK on 06/28/2006

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	)
	)
Plaintiff,	)
	)
vs.	)Case No. 03-CV-
	)0144-CVE
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	)
	)
Defendant.	)

OPINION AND ORDER

On May 22, 2006, Magistrate Judge Sam A. Joyner entered a Report and Recommendation (Dkt. # 43) on plaintiffs Application for Attorney's Fees (Dkt,# 35). Magistrate Judge Joyner recommended that the Court exercise its discretion to deny plaintiff's motion for attorney's fees. See 29 U.S.C. § 1132(g)(1). Plaintiff fled an objection to the Report and Recommendation (Dkt. # 44) pursuant to 28 U.S.C. § 636(b) and Fed. R. Civ. P. 72(b). Rule 72(b) provides that "the district judge to whom the case is assigned shall make a *de novo* review determination upon the record, or after additional evidence."

Accordingly, the Court has conducted a *de novo* review. The Court may accept, reject, or modify the report and recommendation of the Magistrate Judge in whole or in part. For reasons set forth below, the Magistrate Judge's Report and Recommendation (Dkt. # 43) shall be adopted in its entirety.

Plaintiff seeks attorney's fees pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1101 et seq. ("ERISA"). ERISA provides, in relevant part:

> in any action under this subchapter ... by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

29 U.S.C. § 1132(g)(1). This is not a prevailing party statute. In determining whether to award attorney's fees, the Court may consider: evidence of bad faith; the ability of the opposing party to satisfy an award of attorney's fees; whether an award of fees would deter others from future wrongdoing; whether the party requesting fees sought to benefit all participants of an ERISA plan or to resolve a significant legal question regarding ERISA; and the relative merits of the parties' positions. *Gordon v. United States Steel Core.*, 724 F.2d 106, 108 (10th Cir. 1983). The Court considers all five factors articulated in Gordon and finds that each party to this action shall be responsible for its own attorney's fees.

Upon finding that defendant's final decision to deny plaintiff's claim for long term disability benefits was arbitrary and capricious, the Court remanded this case to the administrator of the Rural Letter Carrier Long Term Disability Plan for a full and fair redetermination of the claim. Dkt. # 33. There was no finding of bad faith. Plaintiffs conclusory allegations of defendant's bad faith do not support such a finding. Plaintiff asks the Court to adopt the view that an arbitrary and capricious decision amounts to bad faith. However, these types of

conduct are not identical.[1] In holding that defendant's final denial of plaintiff's claim was arbitrary and capricious, the Court found that defendant lacked substantial evidence to support its conclusion. The Court did not attribute any intent or malice to defendant's decision. Attorney's fees are generally not awarded in a remanded action where there is no definitive finding of bad faith. See e.g., *Lewis v. ITT Hartford Life & Accident Ins. Co.*, 395 F. Supp. 2d 1053, 1065 (D. Kan. 2005).

Defendant concedes that it can afford to satisfy an award of attorney's fees. Further, an award of attorney's fees may deter other administrators from making determinations on disability benefit applications absent substantial evidence. However, these two factors of the Gordon test are not sufficient to merit attorney's fees for plaintiff. The decision of whether to award attorney's fees remains within the discretion of the Court.

Plaintiff did not seek to benefit all participants and beneficiaries of an ERISA plan. Instead, plaintiff pursued this claim specific to her individual claim for long term disability benefits. More importantly, while defendant failed to properly support its decision below, the record does not suggest that plaintiffs claim for benefits is particularly

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[1] "Arbitrary" and "capricious" relate to impulsiveness. Merriam Webster's Collegiate Disctionary, 10th Ed.(1994). These attributes indicate a lack of thorough review and may evidence only negligence. This standard does not equate to bad faith. See Badillo v. Mid Century Ins. Co., 121P.3d 1080, 1094 (Okla. 2005) ("the minimum level of culpability necessary for liability against an insurer to attach is more than simple negligence, but less than the reckless conduct necessary to sanction a punitive damage award against said insurer.").

meritorious. Plaintiff sought "judgment against [defendant] for breach of its duty of good faith and fair dealing, actual damages in an amount in excess of the sum specified by 28 U.S.C. § 1332, exclusive of interest and costs, pain ive damages in an amount in excess of the sum specified by 28 U.S.C. § 1332, exclusive of interest and costs, attorney fees, interest, court costs, and for such other and further relief as this Court deems equitable and proper." Dkt. # 1, at 3. Plaintiff did not prevail on this request. Dkt. # 21 (dismissing plaintiff's bad faith claim). The Court did not hold that "it would be unreasonable for the plan administrator to deny the application for benefits on any ground." See Caldwell v. Life Ins. Co. of North America, 287 F.3d 1276, 1289 (10th Cir. 2002) (citations omitted).

Accordingly, the Court did not award plaintiff disability benefits or compensation, but rather remanded the case for a full and fair reconsideration.

Based on a careful review of the Report and Recommendation, plaintiffs objection, defendant's response, and an independent review of the record and the relevant authorities, the Court finds that the Report and Recommendation (Dkt. # 43) is hereby **adopted**.

IT IS THEREFORE ORDERED that plaintiffs objection to the Report and Recommendation (Dkt. # 44) is **overruled** and plaintiffs Application for Attorney's Fees (Dkt. # 35) is **denied**.

DATED this 28th day of June, 2006.

/s/ Claire V. Eagan
Claire V. Eagan, Chief Judge
United States District Court